What impacts on GP Workload?

Impact of deprivation

“Research by Dr Sally Hull and Dr Kambiz Boomla of the Clinical Effectiveness Group (CEG) at Queen Mary University of London suggests practices in one of the UK's most deprived areas have been underfunded by 33% because of the Carr-Hill formula's failure to recognise how deprivation affects GP workload.”
http://www.gponline.com/why-gp-funding-linked-deprivation/article/1328431


Abstract
PURPOSE The inverse care law states that the availability of good medical care tends to vary inversely with the need for it in the population served, but there is little research on how the inverse care law actually operates.

METHODS A questionnaire study was carried out on 3,044 National Health Service (NHS) patients attending 26 general practitioners (GPs); 16 in poor areas (most deprived) and 10 in affluent areas (least deprived) in the west of Scotland. Data were collected on demographic and socioeconomic factors, health variables, and a range of factors relating to quality of care.

RESULTS Compared with patients in least deprived areas, patients in the most deprived areas had a greater number of psychological problems, more long-term illness, more multimorbidity, and more chronic health problems. Access to care generally took longer, and satisfaction with access was significantly lower in the most deprived areas. Patients in the most deprived areas had more problems to discuss (especially psychosocial), yet clinical encounter length was generally shorter. GP stress was higher and patient enablement was lower in encounters dealing with psychosocial problems in the most deprived areas. Variation in patient enablement between GPs was related to both GP empathy and severity of deprivation.

CONCLUSIONS The increased burden of ill health and multimorbidity in poor communities results in high demands on clinical encounters in primary care. Poorer access, less time, higher GP stress, and lower patient enablement are some of the ways that the inverse care law continues to operate within the NHS and confounds attempts to narrow health inequalities.


Background The NHS Plan promises an equitable distribution of resources within primary care. To inform the debate on the extent to which resources should be redistributed we examined the association between primary care activity and deprivation. We used the
natural experiment of the organization of primary care in Mansfield, Nottinghamshire, where town centre general practices have patients from electoral wards with a range of socio-economic characteristics who are subject to the same degree of supplier-induced demand and variations in data quality.

Methods We used one year's prospective data for two practices with 20,106 patients from 15 electoral wards. We performed linear regression analysis of directly age-standardized rates for different types of primary care activity and primary care morbidity-specific contacts against Townsend and Index of Multiple Deprivation 2000 scores.

Results There were 44 per cent more out-of-hours contacts in more deprived areas (95 per cent confidence interval (CI) 17–70 per cent), 18 per cent more surgery consultations (95 per cent CI 8–27 per cent), and 28 per cent more same-day consultations (95 per cent CI 12–44 per cent). Routine visits by doctors and contacts by district and practice nurses did not have substantial associations with deprivation. Morbidity-specific contacts for psychological problems and respiratory problems were associated with deprivation but there was no significant association for contacts for low back pain, asthma or menopausal problems.

Conclusions Different types of primary care activity and contacts for different morbidities had different associations with deprivation. This makes it difficult to recommend a simple list size adjustment; however, increased activity in deprived wards needs to be recognized in resource allocation, service configuration and performance management in primary care.

GPs’ workload climbs as government austerity agenda bites
http://www.bmj.com/content/349/bmj.g4300.abstract
http://www.bmj.com/content/bmj/349/bmj.g4300.full.pdf

GPs increasingly have to tackle patients’ debt and housing problems
http://www.bmj.com/content/bmj/349/bmj.g4301.full.pdf

Although it is recognised that multi-morbidity increases with increasing age, the onset of multi-morbidity in the most deprived areas occurs 10–15 years earlier than in the most affluent areas (Barnett et al., 2012). This suggests that GPs working in poorer areas are more likely to have younger patients with multiple health problems. This is likely to significantly impact on GP workload and patient complexity.


Summary

Background Long-term disorders are the main challenge facing health-care systems worldwide, but health systems are largely configured for individual diseases rather than multimorbidity. We examined the distribution of multimorbidity, and of comorbidity of physical and mental health disorders, in relation to age and socioeconomic deprivation.

Methods In a cross-sectional study we extracted data on 40 morbidities from a database of 1,751,841 people registered with 314 medical practices in Scotland as of March, 2007. We
analysed the data according to the number of morbidities, disorder type (physical or mental), sex, age, and socioeconomic status. We defined multimorbidity as the presence of two or more disorders.

Findings 42·2% (95% CI 42·1–42·3) of all patients had one or more morbidities, and 23·2% (23·0–23·4) were multimorbid. Although the prevalence of multimorbidity increased substantially with age and was present in most people aged 65 years and older, the absolute number of people with multimorbidity was higher in those younger than 65 years (210 500 vs 194 996). Onset of multimorbidity occurred 10–15 years earlier in people living in the most deprived areas compared with the most affluent, with socioeconomic deprivation particularly associated with multimorbidity that included mental health disorders (prevalence of both physical and mental health disorder 11·0%, 95% CI 10·9–11·2% in most deprived area vs 5·9%, 5·8%–6·0% in least deprived). The presence of a mental health disorder increased as the number of physical morbidities increased (adjusted odds ratio 6·74, 95% CI 6·59–6·90 for five or more disorders vs 1·95, 1·93–1·98 for one disorder), and was much greater in more deprived than in less deprived people (2·28, 2·21–2·32 vs 1·08, 1·05–1·11).

Interpretation Our findings challenge the single-disease framework by which most health care, medical research, and medical education is configured. A complementary strategy is needed, supporting generalist clinicians to provide personalised, comprehensive continuity of care, especially in socioeconomically deprived areas.

**Impact of an older population**


The fact that GPs are working harder is most clearly borne out by the increased number of patient consultations provided. Between 1995 and 2008, the number of patient consultations rose by 75%, from 171 million to more than 300 million. GP consultations rose by 11% and nurse consultations rose by nearly 150%. For the average patient, the number of consultations per year rose from 3.9 in 1995 to 5.5 in 2008, with the biggest increases taking place amongst those aged over 70 years. If the pattern of consultations remains unchanged, by 2035 there could be a total of 433 million GP consultations in England, of which 180 million would be for people aged 65 years and over, nearly double the current number.


The primary care GP workload incurred by those aged 75 and over is roughly three times that of the 45–64 age group

Impact of hospital admission rate?

*Hospital admissions (planned and unplanned) are another useful proxy of GP workload – the lower the admission rate the more work is carried out in the community (including but not exclusively general practice). Activity data collected by the Department of Health (England) show that while hospital and emergency admissions and outpatient attendances have increased year on year, their rate of increase is declining. Assuming that the total amount of health care is not decreasing across the whole health service, and that the health needs of the population are actually increasing, what this indicates is that the work is shifting to the primary and community care parts of the health services.*

So – practices with fewer hospital admissions COULD argue that this is because they work harder to keep patients out of hospital.....

Impact of long-term conditions/multi-morbidities

Though patients with long-term conditions account for around 31% of the population, they make up 52% of all GP appointments,


Caring for patients with long term conditions is at the core of day-to-day practice for GPs, with such patients representing over 50% of GP appointments.

Ref: Department of Health, Improving the health and well-being of people with long term conditions: World class services for people with long term conditions - Information tool for commissioners, January 2010.

Between 2008/09 and 2013/14, the number of GP consultations in England rose by 19%.

Case complexity also increased: the number of patients (in England) with multi-morbidities has risen and is set to increase by 53% between 2008 and 2018.


Patients with multi-morbidities can account for up to 78% of all consultations.


Impact of ethnicity

[http://www.pulsetoday.co.uk/ethnicity-ruled-out-of-carr-hill-despite-workload-evidence/10878310.article#.VdR3mnnLc](http://www.pulsetoday.co.uk/ethnicity-ruled-out-of-carr-hill-despite-workload-evidence/10878310.article#.VdR3mnnLc)

Cannot find CHE paper that this article refers to
Ethnic differences in consultation rates in urban general practice BMJ – published in 1989 so rather out of date?

http://www.bmj.com/content/299/6705/953?variant=abstract

This is trickier to evidence – of course the JSNA contains information about health inequalities relating to BME populations and higher prevalence of some conditions which provides a rationale as to why this may impact on practice workload. However – I can also find studies claiming that BME populations are less likely to access GP services……..

GP workload - Additional references
Ethnicity

This paper reports use of GP services by minority ethnic groups to be as high or higher than the white population. Disaggregation of the ethnic groupings revealed that Chinese people and the sub-group of ‘young Pakistani women’ under-used GP services compared to the white population and there was a general under-use of outpatient services. This raised questions for other researchers and supports discussions elsewhere about the usefulness of large ethnicity categories.

Abstract
This paper addresses the extent to which equity of treatment is received by people of different ethnic groups from the British National Health Service. Using data from the General Household Surveys of 1984–1991 it examines the use of general practitioner, outpatient and inpatient services using three different methods to adjust for need and for other possible confounding variables. The results do not suggest there is any gross pattern of inequity between ethnic groups, except perhaps with respect to the Chinese population which displays consistently low levels of utilisation.

However, while use of GP services by minority ethnic groups is in general as high or higher than the white population, use of outpatient services is low. Some of the results also suggest that there may be important ethnic differences underlying the broader finding of equity. For example, females of Pakistani origin report low levels of GP use. More generally, excess use of GP services among several minority ethnic groups appears to be associated with need, while people from most minority ethnic groups who do not report illness display especially low use of outpatient services relative to the corresponding group in the white population. The paper examines the implications of these findings.

This study shows that low-income individuals and ethnic minorities have lower use of secondary care despite having higher use of primary care

Abstract
Achieving equity in healthcare, in the form of equal use for equal need, is an objective of many healthcare systems. The evaluation of equity requires value judgements as well as analysis of data. Previous studies are limited in the range of health and supply variables considered but show a pro-poor distribution of general practitioner consultations and inpatient services and a pro-rich distribution of outpatient visits. We investigate inequality and inequity in the use of general practitioner consultations, outpatient visits, day cases and inpatient stays in England with a unique linked data set that combines rich information on the health of individuals and their socio-economic circumstances with information on local supply factors. The data are for the period 1998–2000, just prior to the introduction of a set of National Health Service (NHS) reforms with potential equity implications. We find inequalities in utilisation with respect to income, ethnicity, employment status and education. Low-income individuals and ethnic minorities have lower use of secondary care despite having higher use of primary care. Ward level supply factors affect utilisation and are important for investigating health care inequality. Our results show some evidence of inequity prior to the reforms and provide a baseline against which the effects of the new NHS can be assessed.

Literature does report problems with data on ethnicity and consultation rates:
1. Data on GP consultations can sometimes show that BME groups have high rates of consultations. However, this can hide the real picture. ‘More consultations can also be a measure of poor access as repeat consultations may mean that the patient has had to go a few times to get heard. It is about having fewer sessions that are of better quality.’

2. Ethnicity is often poorly recorded therefore hindering attempts to explore associations between minority ethnic groups and consultation rates

Interestingly the 2007 review of the Carr-Hill formula states:
Ethnicity
22. The QRESEARCH analysis suggested that consultation rates decreased as the percentage of the white population increased. We interpreted the negative effect of ethnicity on workload as evidence of unmet need on non-white groups and we agreed that it would therefore be inappropriate to reduce practice payments on the basis of ethnicity.
I don’t understand this – as they are implying that ethnicity DOES impact on consultation rates.

Other areas’ reactions to changes in GP contracts

Tower Hamlets et al
http://www.pulsetoday.co.uk/your-practice/practice-topics/practice-income/ccg-steps-into-support-mpig-threatened-practices/20010571.article#.VdQtFnnbLcs
This briefing was prepared by Christina Maslen, Bristol City Council, Public Health, for the PMS Review Group, Bristol CCG. It was taken as part of the evidence for consideration of the methodologies for reinvestment of the PMS premium and it is noted, was not completed. The PMS Review Group would like to thank Christina for her valuable contribution to the PMS review process.